Maternity Care and Delivery

Prenatal Assessments No Longer Covered

Effective for dates of service on and after July 1, 2004, MAA no longer reimburse providers for prenatal assessments. If a client is seen for reasons other than routine antepartum care, providers must bill using the appropriate Evaluation and Management (E&M) procedure code with a medical diagnosis code. E&M codes billed with ICD-9-CM diagnosis codes V22.0-V22.2 will be denied.

☞ **Exception:** Providers must bill E&M codes for antepartum care if only 1-3 antepartum visits are done, as discussed later in these billing instructions.

Confirmation of Pregnancy

If a client presents with signs or symptoms of pregnancy and the purpose of the client's visit is to confirm the pregnancy, bill this visit using the appropriate level E&M code, assuming that the obstetrical (OB) record is not initiated. If the OB record is initiated at this visit, then the visit is considered part of the global OB package and must not be billed separately.

If some other source has confirmed the pregnancy and the provider wants to do his/her own confirmation, bill this visit using the appropriate level E&M code, assuming that the OB record is not initiated. If the OB record is initiated at this visit, the visit is considered part of the global OB package and must not be billed separately.

If the purpose of the client's visit is to confirm the pregnancy and the OB record is not initiated, bill using the diagnosis code(s) for the signs and/or symptoms the client is having [e.g. suppressed menstruation (ICD-9-CM diagnosis code 626.8)]. Do not bill using the pregnancy diagnosis codes (e.g. V22.0-V22.2) unless the OB record is initiated at this visit. If the OB record is initiated at this visit, the visit is considered part of the global package.

Global (Total) Obstetrical Care

Global OB care (CPT codes 59400, 59510, 59610, or 59618) includes:

- Routine antepartum care in any trimester;
- Delivery; and
- Postpartum care.

If you provide all of the client's antepartum care, perform the delivery, and provide the postpartum care, **you must bill** using one of the global OB procedure codes.

☞ **Note:** **Do not** bill MAA for maternity services until all care is completed.

Unbundling Obstetrical Care

In the situations described below, you may not be able to bill MAA for global OB care. In these cases, it may be necessary to "unbundle" the OB services and bill the antepartum, delivery, and postpartum care separately, as MAA may have paid another provider for some of the client's OB care, or you may have been paid by another insurance carrier for some of the client's OB care.

When a client transfers to your practice late in the pregnancy…

- If the client has had antepartum care elsewhere, you must not bill the global OB package. Bill the antepartum care, delivery, and postpartum care separately. The provider that had been providing the antepartum care bills for the services that he/she performed. Therefore, if you bill the global OB package, you are billing for some antepartum care that another provider has claimed.

- OR -

- If the client did not receive any antepartum care prior to coming to your office, bill the global OB package.

  In this case, you may actually perform all of the components of the global OB package in a short time. MAA does not require you to perform a specific number of antepartum visits in order to bill for the global OB package.

If your client moves to another provider (not associated with your practice), moves out of your area prior to delivery, or loses the pregnancy…

Only those services you actually provided to these clients may be billed to MAA.

If your client changes insurance during her pregnancy…

Often, a client is fee-for-service at the beginning of her pregnancy, and then is enrolled in an MAA managed care plan for the remainder of her pregnancy. MAA is responsible for reimbursing only those services provided to the client while she is on fee-for-service. The plan reimburses for services provided after the client is enrolled with the plan.

When a client changes from one plan to another, bill those services that were provided while she was enrolled with the original plan to the original carrier, and those services that were provided under the new coverage to the new plan. You must unbundle the services and bill the antepartum, delivery, and postpartum care separately.

Antepartum Care

Per CPT guidelines, MAA considers routine antepartum care for a normal, uncomplicated pregnancy to consist of:

- Monthly visits up to 28 weeks gestation;
- Biweekly visits to 36 weeks gestation; and
- Weekly visits until delivery.

Antepartum care includes:

- Initial and subsequent history;
- Physical examination;
- Recording of weight and blood pressure;
- Recording of fetal heart tones;
- Routine chemical urinalysis; and
- Maternity counseling, such as risk factor assessment and referrals.

Necessary prenatal laboratory tests may be billed in addition to antepartum care, **except for dipstick tests** (CPT codes 81000, 81002, 81003, and 81007).

Coding for Antepartum Care Only

If it is necessary to unbundle the OB package and bill separately for antepartum care, bill as follows:

- If the client had a **total** of one to three antepartum visits, bill the appropriate level of **E&M service with modifier TH** for each visit, with the date of service the visit occurred and the appropriate diagnosis.

  Modifier TH: Obstetrical treatment/service, prenatal or postpartum

- If the client had a **total** of four to six antepartum visits, bill using **CPT code 59425** with a "1" in the units box. Bill MAA using the date of the last antepartum visit in the "to and from" fields.

- If the client had a **total** of seven or more visits, bill using **CPT code 59426** with a "1" in the units box. Bill MAA using the date of the last antepartum visit in the "to and from" fields.

Do not bill antepartum care only codes in addition to any other procedure codes that include antepartum care (i.e. global OB codes).

When billing for antepartum care, **do not bill** using CPT E&M codes for the first three visits, then CPT code 59425 for visits four through six, and then CPT code 59426 for visits seven and on. These CPT codes are used to bill only the **total** number of times you saw the client for all antepartum care during her pregnancy, and **may not** be billed in combination with each other during the entire pregnancy period.

☞ **Note: Do not** bill MAA until all antepartum services are complete.

Coding for Deliveries

If it is necessary to unbundle the OB package and bill for the delivery only, you must bill MAA using one of the following CPT codes:

- 59409 (vaginal delivery only);
- 59514 (cesarean delivery only);
- 59612 [vaginal delivery only, after previous cesarean delivery (VBAC)]; or
- 59620 [cesarean delivery only, after attempted vaginal delivery after previous cesarean delivery (attempted VBAC)].

If you do not provide antepartum care, but perform the delivery and provide postpartum care, bill MAA one of the following CPT codes:

- 59410 (vaginal delivery, including postpartum care);
- 59515 (cesarean delivery, including postpartum care);
- 59614 (VBAC, including postpartum care); or
- 59622 (attempted VBAC, including postpartum care).

Coding for Postpartum Care Only

If it is necessary to unbundle the OB package and bill for postpartum care only, you must bill MAA using CPT code 59430 (postpartum care only).

If you provide all of the antepartum and postpartum care, but do not perform the delivery, bill MAA for the antepartum care using the antepartum care only codes, along with CPT code 59430 (postpartum care only).

Do not bill CPT code 59430 (postpartum care only) in addition to any procedure codes that include postpartum care.

Additional Monitoring for High-Risk Conditions

When providing **additional monitoring** for high-risk conditions in excess of the CPT guidelines for normal antepartum visits, bill using E&M **codes 99211-99215 with modifier TH.** The office visits may be billed in addition to the global fee **only after** exceeding the CPT guidelines for normal antepartum care.

A condition that is classifiable as high-risk **alone** does not entitle the provider to additional payment. Per CPT guidelines, it must be medically necessary to see the client **more often** than what is considered routine antepartum care in order to qualify for additional payments. The additional payments are intended to cover additional costs incurred by the provider as a result of more frequent visits. **For example:**

> Client A is scheduled to see her provider for her antepartum visits on January 4, February 5, March 3, and April 7. The client attends her January and February visits, as scheduled. However, during her scheduled February visit, the provider discovers the client's blood pressure is slightly high and wants her to come in on February 12 to be checked again. At the February 12 visit, the provider discovers her blood pressure is still slightly high and asks to see her again on February 18. The February 12 and February 18 visits are outside of her regularly scheduled antepartum visits and outside of the CPT guidelines for routine antepartum care since she is being seen more often than once per month. The February 12 and February 18 visits may be billed separately from the global antepartum visits using the appropriate E&M codes with modifier TH, and the diagnosis must represent the medical necessity for billing additional visits. **A normal pregnancy diagnosis (i.e. V22.0 – V22.2) will be denied outside of the global antepartum care**. It is not necessary to wait until all services included in the routine antepartum care are performed to bill the extra visits, as long as the extra visits are outside of the regularly scheduled visits.

Labor Management

Providers may bill for labor management **only** when another provider (outside of your group practice) performs the delivery. If you performed all of the client's antepartum care, admitted the client to the hospital during labor, delivered the baby, and performed the postpartum care, **do not** bill MAA for the hospital admission or for labor management. These services are included in the global OB package.

If, however, you performed all of the client's antepartum care and admitted the client to the hospital during labor, but another provider (outside of your group practice) takes over delivery, you must unbundle the global OB package and bill separately for antepartum care, the hospital admission, and the time spent managing the client's labor. The client must be in active labor and admitted to a hospital when the referral to the delivering provider is made.

To bill for labor management in the situation described above, bill MAA for one of the hospital admission CPT **codes 99221-99223 with modifier TH**. In addition to the hospital admission, MAA reimburses providers for **up to three hours** of labor management using prolonged services CPT **codes 99354-99357 with modifier TH**. Reimbursement for prolonged services is limited to three hours per client, per pregnancy, regardless of the number of calendar days a client is in labor, or the number of providers who provide labor management. **Labor management may not be billed by the delivering provider, or by any provider within the delivering provider's group practice**.

☞ **Note**: The hospital admission code and the prolonged services code(s) **must** be billed on the same claim form.

High-Risk Deliveries

Delivery includes management of uncomplicated labor and vaginal delivery (with or without episiotomy, with or without forceps) or cesarean section. If a complication occurs during delivery resulting in an unusually complicated, high-risk delivery, MAA reimburses providers an additional add-on fee. Bill the high-risk add-on fee by **adding modifier TG to the delivery code** (e.g. 59400 TG or 59409 TG).

Modifier TG: Complex/high level of care

The ICD-9-CM diagnosis code **must clearly** demonstrate the medical necessity for the high-risk delivery add-on (e.g. a diagnosis of fetal distress). A normal delivery diagnosis is not paid an additional high-risk add-on fee, even if the mother had a high-risk condition during the antepartum period.

Bill only ONE line of service (e.g. 59400 TG) to receive reimbursement for BOTH the delivery and the high-risk add-on. DO NOT bill the delivery code (e.g. 59400) on one line of the claim form and the high-risk add-on (e.g. 59400 TG) on a second line of the claim form.

A physician who provides stand-by attendance for high-risk delivery can bill CPT code 99360 and resuscitation CPT code 99440, when appropriate.

☞ **Note:** MAA **does not** reimburse an assistant surgeon, RNFA, or co-surgeon for a high-risk delivery add-on. Reimbursement is limited to one per client, per pregnancy (even in the case of multiple births).

Consultations

If another provider refers a client during her pregnancy for a consultation, bill MAA using consultation CPT codes 99241-99255. If a follow-up consultation is necessary, bill using CPT codes 99261-99263. You **must** list the referring physician's name and MAA-assigned provider number in the "Referring Physician" field on the claim form.

If the consultation results in the decision to perform surgery (i.e. a cesarean section), MAA reimburses the consulting physician for the consultation as follows:

- If the consulting physician does not perform the cesarean section, bill MAA the appropriate consultation code.

- If the consulting physician performs the cesarean section and does the consultation **two or more days prior to the date of surgery**, bill MAA the appropriate **consultation code with modifier 57** (e.g. 99241-57).

MAA does not reimburse the consulting physician if the following applies:

- If the consulting physician performs the cesarean section and does the consultation **the day before or the day of the cesarean section**, the consultation is bundled within payment for the surgery. **Do not bill** MAA for the consultation in this situation.

Bill consultations with an appropriate ICD-9-CM medical diagnosis code. You must demonstrate the medical necessity (i.e. sign, symptom, or condition). MAA does not reimburse providers for a consultation with a normal pregnancy diagnosis code (e.g. V22.0-V22.2).

MAA reimburses consulting OB/GYN providers for an external cephalic version (CPT code 59412) and a consultation when performed on the same day.

General Obstetrical Payment Policies and Limitations

- MAA reimburses a multiple vaginal delivery (for twins, triplets, etc.) at 100% for the first baby. When billing for the second or third baby, you must bill using the delivery-only code (CPT code 59409 or 59612) for each additional baby. Reimbursement for each additional baby will be 50% of the delivery-only code's maximum allowance. Bill each baby's delivery on a separate line. Identify on the claim form as "twin A" or "twin B," etc.

- MAA reimburses for multiple births by cesarean delivery at 100% for the first baby. No additional reimbursement will be made for additional babies.

- An assistant surgeon may bill for an assist at c-section by adding modifier 80, 81, or 82 to the delivery only code (e.g. 59514-80). Reimbursement is 20% of the delivery-only code's maximum allowance.

- Physician assistants (PA) must bill for an assist at c-section **on the same claim form** as the physician performing the delivery by adding modifier 80, 81, or 82 to the delivery-only code (e.g. 59514-80). The claim must be billed using the delivering physician's provider number.

- RNFAs assisting at c-sections may **only** bill using CPT code 59514 or 59620 with modifier 80.

- To bill for anesthesia during delivery, see the Anesthesia Section (page F.26).

- For deliveries in a birthing center, refer to MAA's Births in Birthing Centers Billing Instructions. For deliveries in a home birth setting, refer to MAA's Planned Home Births Billing Instructions.

☞ **Note**: Maternity Support Services/Infant Case Management (MSS/ICM) is a program designed to help pregnant women and their newborns gain access to medical, social, educational and other services. This program provides a variety of services for both the woman and/or her child in the home or clinic throughout pregnancy and up to 60 days after delivery. For information on MSS/ICM, call MAA's Family Services Section at (360) 725-1655.

For your convenience, a table summarizing "Billing MAA for Maternity Services" is included on the following pages.

Global (Total) Obstetrical (OB) Care

Service	Procedure Code/Modifier	Summary of Description	Limitations
Confirmation of pregnancy	99201-99215	Office visits	Code the sign or symptom (e.g. suppressed menstruation)
Global OB care	59400	Total OB care, vaginal delivery	Includes all antepartum, delivery, and postpartum care; bill after all services are complete; limited to one per client, per pregnancy; additional vaginal deliveries for multiple bills must be billed with the appropriate delivery-only code.
	59510	Total OB care, c-section	
	59610	Total OB care, VBAC	
	59618	Total OB care, attempted VBAC	

Antepartum Care Only

Service	Procedure Code/Modifier	Summary of Description	Limitations
Antepartum care (bill **only one** of these codes to represent the total number of times you saw the client for antepartum care)	99201-99215 TH	Offices visits, antepartum care 1-3 visits only, with OB service modifier	Limited to 3 units when used for routine antepartum care. Must bill with modifier TH.
	59425	Antepartum care, 4-6 visits	Limited to one unit per client, per pregnancy, per provider
	59426	Antepartum care, 7+ visits	Limited to one unit per client, per pregnancy, per provider.

Deliveries

Service	Procedure Code/Modifier	Summary of Description	Limitations
Delivery only	59409	Vaginal delivery only	Must not be billed with any other codes that include deliveries; assist at c-section must be billed with delivery-only code with modifier 80.
	59514	C-Section delivery only	
	59612	VBAC delivery only	
	59620	Attempted VBAC delivery only	
Delivery with postpartum care	59410	Vaginal delivery including postpartum care	Must not be billed with any other codes that include deliveries; must not be billed with postpartum only code; limited to one per client, per pregnancy; additional vaginal deliveries for multiple births must be billed using the appropriate delivery-only code.
	59515	C-Section delivery with postpartum care	
	59614	VBAC including postpartum care	
	59622	Attempted VBAC including postpartum care	

Postpartum Care Only

Service	Procedure Code/Modifier	Summary of Description	Limitations
Postpartum care only	59430	Postpartum care only	Must not be billed with any other codes that include postpartum care; limited to one per client, per pregnancy.

Additional Monitoring for High-Risk Conditions

Service	Procedure Code/Modifier	Summary of Description	Limitations
Additional visits for antepartum care due to high-risk conditions	99211-99215 TH	Office visits with OB service modifier	Must not be billed with a normal pregnancy diagnosis (V22.0-V22.2); diagnosis must detail need for additional visits; must be billed with modifier TH.

Labor Management

Service	Procedure Code/Modifier	Summary of Description	Limitations
Labor management (may only be billed when another provider takes over and delivers the infant)	99221-99223 TH	Hospital admit services with OB services modifier	Prolonged services are limited to 3 hours per client, per pregnancy; must be billed with modifier TH; **must not be billed by delivering provider**. Admit code with modifier TH and the prolonged services code(s) **must be billed on the same claim form.**
	+99356 **Limited to 1 unit**	Prolonged services, inpatient setting, 1st hour	
	+99357 **Limited to 4 units**	Prolonged services, inpatient setting, each add'l 30 minutes	

High-Risk Deliveries

Service	Procedure Code/Modifier	Summary of Description	Limitations
High-risk delivery *[Not covered for assistant surgeons, co-surgeons, or RNFA]*	Add modifier TG to the delivery code (e.g. 59400 TG)	Complex/high level of care	Diagnosis must demonstrate medical necessity; not paid with normal delivery diagnosis; limited to one per client, per pregnancy. Bill only **ONE** line of service (e.g. 59400 TG) for **BOTH** the delivery and high-risk add-on.

Smoking Cessation for Pregnant Women

MAA reimburses providers for smoking cessation counseling as part of an antepartum care visit or a post-pregnancy office visit for tobacco dependent eligible pregnant women.

What is Smoking Cessation Counseling?

Smoking cessation counseling consists of provider information and assistance to help the client stop smoking. Smoking cessation counseling includes the following steps:

- Step 1: Asking the client about her smoking status;
- Step 2: Advising the client to stop smoking;
- Step 3: Assessing the client's willingness to set a quit date;
- Step 4: Assisting the client to stop smoking, which includes a written quit plan. If the provider considers it appropriate for the client, the "assisting" step may also include prescribing smoking cessation pharmacotherapy, as needed (see next page); and
- Step 5: Arranging to track the progress of the client's attempt to stop smoking.

Who is eligible for smoking cessation counseling?

Fee-for-service: Tobacco dependent, pregnant women covered under fee-for-service are eligible for smoking cessation counseling.

Managed Care: Tobacco dependent, pregnant women who are enrolled in a managed care plan must have services arranged and referred by their primary care provider (PCP). Clients covered under a managed care plan will have a plan indicator in the HMO column on their Medical Identification card. Do not bill MAA for Smoking Cessation Counseling as it is included in the managed care plans' reimbursement rates.

Who is eligible to be reimbursed for smoking cessation counseling?

MAA will reimburse only the following providers for smoking cessation counseling as part of an antepartum care visit or a post-pregnancy office visit (which must take place within two months following live birth, miscarriage, fetal death, or pregnancy termination):

- Physicians;
- Physician Assistants (PA) working under the guidance and billing under the provider number of a physician;
- Advanced Registered Nurse Practitioners (ARNP); and
- Licensed Midwives (LM), including certified nurse midwives (CNM).

What is covered?

MAA allows one smoking cessation counseling session per client, per day, up to 10 sessions per client, per pregnancy. The provider must keep written documentation in the client's file for each session. The documentation must reflect the information listed on the following page.

MAA covers two levels of counseling:

- Basic counseling (approximately 15 minutes) which includes Steps 1-3 on previous page; and
- Intensive counseling (approximately 30 minutes) which includes Steps 1-5 on previous page.

Use the most appropriate procedure code from the following chart when billing for smoking cessation:

CPT Procedure Code	Brief Description	Restricted to Diagnoses:
99401	Preventive counseling, indiv [approximately 15 minutes]	648.43 (antepartum) 648.44 (postpartum)
99402	Preventive counseling, indiv [approximately 30 minutes]	648.43 (antepartum) 648.44 (postpartum)

A provider may prescribe pharmacotherapy for smoking cessation for a client when the provider considers the treatment appropriate for the client. MAA covers pharmacotherapy for smoking cessation as follows:

- MAA covers Zyban® only;
- The product must be prescribed by a physician, ARNP, or PA;
- The client for whom the product is prescribed must be 18 years of age or older;
- The **pharmacy provider must obtain prior authorization** from MAA when filling the prescription for pharmacotherapy; and
- The provider must include both of the following on the client's prescription:

  ✓ The client's estimated or actual delivery date; and
  ✓ Notation that the client is participating in smoking cessation counseling.

To obtain prior authorization for Zyban®, pharmacy providers must call:

Drug Utilization and Review
1-800-848-2842

Smoking Cessation Form Here

Abortion Services (Drug Induced)

- Methotrexate and misoprostol are two drugs approved by the Food and Drug Administration (FDA) for use in inducing abortions.

  ✓ J9260 Methotrexate sodium, 50 mg
  ✓ S0191 Misoprostol, oral, 200 mcg

- When these drugs are used for abortion services, providers must bill using the appropriate ICD-9-CM abortion diagnosis code. Other medical services (laboratory, history/physical, ultrasound, etc.) performed at the time of the drug administration must be billed on the same claim as the abortion drugs.

- Rho(D) immune globulin must be billed using the appropriate HCPCS codes.

- **RU-486 Abortion Drug**

  MAA pays for RU-486 for medically induced abortions provided through physicians' offices using the codes in the following table. Office visits, laboratory tests, and diagnostic tests performed for the purpose of confirming pregnancy, gestational age, and successful termination must be billed on the same claim form as the abortion drugs.

Bill HCPCS Code	Description
S0190	Mifepristone, oral, 200 mg
S0191	Misoprostol, oral, 200 mcg

Abortion Center Contracts (Facility Fees)

- For providers who currently have an abortion center contract with MAA, facility fees are payable only for surgical abortions. Do not bill facility fee charges for drug-induced abortions not requiring surgical intervention.

- Contracted facility fee reimbursement includes all room charges, equipment, supplies, and drugs (including anti-anxiety, anesthesia, and pain medications, but excluding Rho(D) immune globulins). **Reimbursement is limited to one special agreement facility fee per client, per abortion.** The facility fee is not payable per visit, even though a particular procedure or case may take several days or visits to complete.

Chemotherapy Services [Refer to WAC 388-531-0950(11)]

Chemotherapy Administration

When chemotherapy is administered in the physician's office, but there is no face-to-face contact with the physician, CPT E&M code 99211 may be used to bill for this service if:

- The physician personally supervises the services furnished by office medical staff; and
- The client's medical record reflects the physician's active participation in or management of treatment.

If a significant, separately identifiable E&M service is performed on the same day as chemotherapy administration, the appropriate E&M code may be reported in addition to the chemotherapy administration codes (CPT codes 96400-96549).

Chemotherapy administration, push technique (CPT code 96408), may be reported **for each drug administered.**

Chemotherapy Drugs

The following reimbursement guidelines apply to chemotherapy drugs (HCPCS codes J9000-J9999):

- MAA's maximum allowable fee per unit is based on the HCPCS description of the chemotherapy drug.
- MAA's maximum allowable fee is equal to 86% of the average wholesale price (AWP) or Medicare's rates, whichever is less.
- Preparation of the chemotherapy drug is included in the administration of the drug.

Billing for Single-Dose Vials:

For single-dose vials, bill the total amount of the drug contained in the vial(s), including partial vials. Based on the unit definition for the HCPCS code, MAA reimburses providers for the total number of units contained in the vial. **For example:**

> If a total of 150 mg of Etoposide is required for the therapy, and two 100 mg single dose vials are used to obtain the total dosage, then the total of the two 100 mg vials is reimbursed. In this case, the drug is billed using HCPCS code J9181 (Etoposide, 10 mg). If MAA's maximum allowable fee is $4.38 per 10 mg unit, the total allowable is $87.60 (200 mg divided by 10 = 20 units x $4.38).

Billing for Multi-Dose Vials:

For multi-dose vials, bill **only** the amount of the drug administered to the client. Based on the unit definition (rounded up to the nearest whole unit) of the HCPCS code, MAA reimburses providers for only the amount of drug administered to the client. **For example:**

> If a total of 750 mg of Cytarabine is required for the therapy, and is taken from a 2,000 mg multi-dose vial, then only the 750 mg administered to the client is reimbursed. In this case, the drug is billed using HCPCS code J9110 (Cytarabine, 500 mg). If MAA's maximum allowable fee is $23.75 per 500 mg unit, the total allowable is $47.50 [750 mg divided by 500 = 2 (1.5 rounded) units x $23.75].

Unlisted Drugs:

When it is necessary to bill MAA for a chemotherapy drug using an unlisted drug code, you must report the National Drug Code (NDC) of the drug administered to the client. MAA uses the NDC when unlisted drug codes are billed in order to appropriately price the claim. Claims must include:

- The dosage (amount) of the drug administered to the client; and
- The 11-digit NDC of the office-administered drug.

For claims billed using a paper HCFA-1500 claim form, list the required information in field 19 of the claim form.

For claims billed using an electronic HCFA-1500 claim form, list the required information in the *Comments* section of the claim form.

For claims billed using an electronic 837P claim form, list the required NDC information in DRUG IDENTIFICATION Loop 2410, LIN02, and LIN03. List the dosage given to the client in the *Comments* section of the claim form.

Note: If there is an assigned HCPCS code for the administered drug, you **must bill** MAA using the appropriate HCPCS code. **DO NOT** use an unlisted drug code to bill for a drug that has an assigned HCPCS code. MAA will recoup payment for any drugs paid using an unlisted drug code if an assigned HCPCS code exists for the administered drug.

Invoice Requirements

A copy of the manufacturer's invoice showing the **actual acquisition cost** of the drug must be attached to the claim **ONLY** when billed charges exceed $1,100.00 per line item. If billed charges are less than $1,100.00 per line item, **DO NOT** attach the invoice or any other paperwork to your claim. If needed, MAA will request any other necessary documentation after receipt of the claim.

This requirement applies to **all drugs** administered in the provider's office, including those drugs with an assigned CPT or HCPCS code, and those drugs billed using either unlisted drug code J3490 or J9999.

A copy of any manufacturer's invoices for all drugs (regardless of billed charges) must be maintained in the client's record and made available to MAA upon request.

Oral Anti-Emetic Drugs

In order to bill MAA for oral anti-emetic drugs (HCPCS codes Q0163-Q0181) the drug must be:

- Part of a chemotherapy regimen;
- Administered or prescribed for use immediately before, during, or within 48 hours after administration of the chemotherapy drug;
- Billed using one of the ICD-9-CM diagnosis codes 140.0-239.9 (excluding 210.0-229.9) or V58.1; and
- Submitted on the same claim form with one of the chemotherapy drug codes (HCPCS codes J8530-J9999).

Hydration Therapy with Chemotherapy

Intravenous (IV) infusion of saline (CPT codes 90780-90781) is not reimbursed separately when administered at the same time as chemotherapy infusion (CPT codes 96410, 96412, or 96414). Separate reimbursement is allowed for IV infusion when administered separately from the chemotherapy infusion. In this case, bill using the IV infusion code with modifier 59.

Surgical Services [Refer to WAC 388-531-1700]

Global surgery reimbursement includes all the following services:

- The surgical procedure;
- For major surgeries (90-day global period), preoperative visits (all sites of service) that occur the day before or the day of the surgery;
- For minor surgeries (less than 90-day global period), preoperative visits (all sites of service) that occur on the day of surgery;
- Services by the primary surgeon (all sites of service) during the postoperative period;
- Postoperative dressing changes, including:
  - ✓ Local incision care and removal of operative packs;
  - ✓ Removal of cutaneous sutures, staples, lines, wires, tubes, drains and splints;
  - ✓ Insertion, irrigation and removal of urinary catheters, routine peripheral IV lines, nasogastric and rectal tubes; and
  - ✓ Change and removal of tracheostomy tubes.
- Additional medical or surgical services required because of complications that do not require additional operating room procedures.

☞ **Note:** Casting materials are not part of the global surgery policy and are paid separately.

Global Surgery Reimbursement

- The global surgery reimbursement period applies to any provider who participates in the surgical procedure. These providers include:
  - ✓ The surgeon;
  - ✓ The assistant surgeon (modifiers 80, 81, or 82);
  - ✓ Two surgeons (modifier 62);
  - ✓ Team surgeons (modifier 66); and
  - ✓ Anesthesiologists and CRNAs.

- The following procedure codes are bundled within the payment for the surgical procedure during the global period:

Procedure Code	Summary of Description
E&M Services	
99211-99223	Office visits, initial hospital observation care, and initial hospital inpatient care.
99231-99239	Subsequent hospital care, observation or inpatient care services, and hospital discharge services.
99241-99245	Office consultations
99251-99255	Initial inpatient consultations
99261-99263	Follow-up inpatient consultations
99271-99275	Confirmatory consultations
99291-99292	Critical care services.
99301-99303	Comprehensive nursing facility assessments
99311-99316	Subsequent nursing facility care
99331-99333	Domiciliary, rest home, or custodial care services
99347-99350	Home services
99374-99377	Care plan oversight services
Ophthalmological Services	
92012-92014	General ophthalmological services

The E&M codes listed above may be allowed if there is a separately identifiable reason for the additional E&M service unrelated to the surgery. In these cases, the E&M code must be billed with one of the following modifiers:

Modifier	**Description**
24	Unrelated E&M service by the same physician during a postoperative period (reason for the E&M service must be unrelated to the procedure)
25	Significant, separately identifiable E&M service by the same physician on the same day of a procedure (reason for the E&M service must be unrelated to the procedure)
57	Decision for surgery (only applies to surgeries with a 90-day global period)
79	Unrelated procedure or service by the same physician during the postoperative period

- Professional inpatient services (CPT codes 99221-99223) are payable only during the global follow-up period if they are performed on an emergency basis (i.e. they are not payable for scheduled hospital admissions).

- Bundled procedure codes are not payable during the global surgery reimbursement period.

- A provider (other than the surgeon) who provides all postoperative care (including all inpatient postoperative care) before discharge, must bill subsequent hospital care codes (CPT codes 99231-99233) for the inpatient hospital care, and the surgical code with modifier 55 for the post-discharge care. The surgeon must bill the surgery code with modifier 54.

- Providers who perform only the follow-up services for minor procedures performed in emergency departments must bill the appropriate level E&M code. These services are not included in the global surgical reimbursement.

- The provider who performs the emergency room service must bill for the surgical procedure without using modifier 54.

- Preoperative and postoperative critical care services provided during a global period for a seriously ill or injured client are not considered related to a surgical procedure and are paid separately when all of the following apply:

  - ✓ The client is critically ill or injured and requires the constant attendance of the provider;
  - ✓ The critical care is unrelated to the specific anatomic injury or general surgical procedure performed; and
  - ✓ The client is potentially unstable or has conditions that could pose a significant threat to life or risk of prolonged impairment.

  Bill the appropriate critical care codes with either modifier 24 or 25.

- MAA allows separate reimbursement for:

  - ✓ The initial evaluation to determine need for surgery;
  - ✓ Preoperative visits that occur two or more days before the surgery;
  - ✓ Postoperative visits for problems unrelated to the surgery;
  - ✓ Postoperative visits for services that are not included in the normal course of treatment for the surgery; and
  - ✓ Services of other providers, except when more than one provider furnishes services that are included in a global package (see modifiers 54 and 55).

Registered Nurse First Assistants (RNFA)

Registered Nurse First Assistants (RNFAs) are allowed to assist at surgeries within their scope of practice. Use modifier 80 to bill MAA for these services. Current RNFA providers who want to assist at surgeries need to submit their Certification as a Certified Nurse Operating Room (CNOR) from the Certification Board Perioperative Nursing to:

Provider Enrollment
PO Box 45562
Olympia, Washington 98504-5562

New RNFA providers must meet the following criteria:

- Licensed in Washington State as a Registered Nurse in good standing;
- Work under the direct supervision of the performing surgeon; and
- Submit the following documentation to MAA along with the Core Provider Agreement:

  - ✓ Certification as a Certified Nurse Operating Room (CNOR) from the Certification Board Perioperative Nursing;
  - ✓ Proof of Allied Health Personnel privileges in the hospital where the surgeries are performed; and
  - ✓ Certification as an RNFA from the Certification Board of Perioperative Nursing.

RNFAs who are current providers or who wish to bill only for cesarean sections (CPT codes 59514 and 59620) **do not need** to submit the Certification as an RNFA from the Certification Board Perioperative Nursing.

Multiple Surgeries

When multiple surgeries are performed on the same client, during the same operative session, MAA reimburses providers as follows:

- 100% of MAA's maximum allowable fee for the most expensive procedure; plus,
- 50% of MAA's maximum allowable fee for each of the second through the fifth procedures.

To expedite payment of your claims, bill all surgeries performed during the same operative session on the same claim.

If a partial payment is made on a claim with multiple surgeries, you must adjust your paid claim using a blue Adjustment Request form (DSHS 525-109).

Endoscopy Procedures

Endoscopy procedures are paid as follows:

- When multiple endoscopies from the same endoscopy group are performed on the same day, the procedure with the highest maximum allowable fee is paid the full amount. The second, third, etc., are paid at the maximum allowable amount minus the base endoscopy procedure's allowed amount.

- When multiple endoscopies from different endoscopy groups are billed, the multiple surgery rules detailed above apply.

- When payment for other procedures within an endoscopy group is less than the endoscopy base code, no payment is made.

- MAA does not reimburse for an E&M visit on the same day as the diagnostic or surgical endoscopy procedure unless there is a separately identifiable service unrelated to the endoscopy procedure. If appropriate, bill the E&M code with modifier 25.

Other Surgical Policies

- Use modifiers 80, 81 and/or 82 to bill for an assistant surgeon. An assist at major surgery is paid at 20% of the surgical procedure's maximum allowable fee. The multiple surgery rules apply for surgery assists.

- A properly completed consent form must be attached to all claims for sterilization and hysterectomy procedures (see Section H).

- MAA reimburses for the use of an operating microscope (CPT code 69990) only when billed with one of the following CPT codes:

  - ✓ 61304-61546;
  - ✓ 61550-61711;
  - ✓ 62010-62100;
  - ✓ 63081-63308;
  - ✓ 63704-63710; or
  - ✓ 64831-64907.

- The surgeries listed in the following table are limited as follows:

CPT Code(s)	Description	Limitations
11960	Insertion of tissue expander(s)	Limited to ICD-9-CM diagnoses: ✓ V10.3; ✓ 140.0-239.9; ✓ 757.6; ✓ 759.4; ✓ 906.5-906.9; or, ✓ 940.0-949.5.
11970	Replace tissue expander	
11971	Remove tissue expander(s)	
19160	Removal of breast tissue	
19162	Remove breast tissue, nodes	
19180	Removal of breast	
19182	Removal of breast	
19316	Suspension of breast	
19340	Immediate breast prosthesis	
19342	Delayed breast prosthesis	
19350	Breast reconstruction	
19357	Breast reconstruction	
19361	Breast reconstruction	
19364	Breast reconstruction	
19366	Breast reconstruction	
19367	Breast reconstruction	
19368	Breast reconstruction	
19369	Breast reconstruction	
19370	Surgery of breast capsule	
19371	Removal of breast capsule	
19380	Revise breast reconstruction	

- Subcutaneous hormone pellet implantation (CPT code 11980) is payable only with ICD-9-CM diagnosis codes 174-174.9 or 257.2.

- Salpingostomies (CPT codes 58673 and 58770) are payable only for a tubal pregnancy (ICD-9-CM diagnosis code 633.1, 633.10, and 633.11).

- Modifier 53 must be used when billing for incomplete colonoscopies (CPT code 45378, or HCPCS codes G0105 or G0121). Do not bill incomplete colonoscopies as sigmoidoscopies. Modifier 53 indicates that the physician elected to terminate a surgical procedure. Use of modifier 53 is allowed for all surgical procedures. Modifier 53 is a payment modifier when used with CPT code 45378 or HCPCS codes G0105 or G0121 only. It is "informational only" for all other surgical procedures.

Epiphyseal

Epiphyseal surgical procedures (CPT codes 25450, 25455, 27185, 27475, 27477-27485, 27742, and 27730-27740) are allowed only for clients age 17 and younger.

Closure of Enterostomy

Mobilization of splenic flexure (CPT code 44139) is not reimbursed when billed with enterostomy procedures (CPT codes 44625 and 44626). CPT code 44139 must be used only in conjunction with partial colectomy (CPT codes 44140 through 44147).

Angioscopy

MAA reimburses for one unit of angioscopy (CPT code 35400), per session.

Apheresis

Therapeutic apheresis (CPT codes 36511-36512) includes payment for all medical management services provided to the client on the date of service. MAA reimburses for only one unit of either CPT code per client, per day, per provider.

Separate payment is not allowed for the following procedures on the same date that therapeutic apheresis services are provided, unless they are billed with modifier 25:

- Established patient office and other outpatient visits (CPT codes 99211-99215);
- Subsequent hospital care (CPT codes 99231-99233); and
- Follow-up inpatient consultations (CPT codes 99261-99263).

Do not bill apheresis management when billing for critical care time (CPT codes 99291-99292).

Urology

Circumcisions (CPT codes 54152 and 54161)

Circumcisions are only allowed for one of the following diagnoses:

- Phimosis (ICD-9-CM 605);
- Balanoposthitis (ICD-9-CM 607.1); or
- Balnitis Xerotica (ICD-9-CM 607.81).

Urinary Tract Implants

Prior to inserting a urinary tract implant (CPT code 51715), the provider must:

- Have urology training in the use of a cystoscope and must have completed a urinary tract implant training program for the type of implant used.
- Document that the client has shown no incontinence improvement through other therapies for at least 12 months prior to collagen therapy.
- Administer and evaluate a skin test for collagen sensitivity (CPT code 95028) over a four-week period prior to collagen therapy. A negative sensitivity must be documented in the client's record.

Refer to Section K for those urinary tract implants covered by MAA. **All services provided and implant codes must be billed on the same claim form**

Urological Procedures with Sterilizations in the Description

These procedures may stop in MAA's payment system as a result of MAA's effort to remain in compliance with federal sterilization consent form requirements. If the surgery is not being done for the purpose of sterilization, or the sterilizing portion of the procedure is not being performed, a sterilization consent form is not required. However, you must note one of the following in the *Comments* section of your claim:

- Not sterilized; or
- Not done primarily for the purpose of sterilization.

Indwelling Catheter

- Separate payment is allowed for insertion of a temporary, indwelling catheter when it is used to treat a temporary obstruction and is performed in a physician's office.
- Bill for the insertion of the indwelling catheter using CPT code 51702 or 51703.
- MAA reimburses providers for insertion of an indwelling catheter only when performed in an office setting.
- Insertion of an indwelling catheter is bundled when performed on the same day as a major surgery.
- Insertion of an indwelling catheter is bundled when performed during the post-operative period of a major surgery.

Bilateral Procedures

- If a procedure is done bilaterally and is not identified by its terminology as a bilateral procedure, bill the procedure with modifier 50. Bill as a single line item on the claim.
- If a procedure is done bilaterally and is identified by its terminology as bilateral (e.g. CPT codes 27395 or 52290), do not bill the procedure with modifier 50.
- Use Modifiers LT and RT to indicate left and right for unilateral procedures.

Pre-/Intra-/Postoperative Payment Splits

Pre-, intra-, and postoperative payment splits are made when modifiers 54, 55, and 56 are used.

MAA has adopted Medicare's payment splits, as listed below. If Medicare has not assigned a payment split to a procedure, MAA uses a payment split of 10% / 80% / 10%.

Code Range	Operative System	Pre-	Intra-	Postoperative
10000 - 19499	Integumentary	10%	71%	19%
20000 - 29909	Musculoskeletal	10%	69%	21%
30000 - 32999	Respiratory	10%	76%	14%
33010 - 37788	Cardiovascular	09%	84%	07%
37790 - 37799	Cardiovascular	08%	83%	09%
38100 - 38115	Hemic/Lymphatic	11%	73%	16%
38120 - 38300	Hemic/Lymphatic	09%	84%	07%
38305 - 38999	Hemic/Lymphatic	11%	73%	16%
39000 - 39599	Mediastinum/Diaphragm	09%	84%	07%
40490 - 43641	Digestive	09%	81%	10%
43651 - 43652	Digestive	11%	76%	13%
43653 - 49999	Digestive	09%	81%	10%
50010 - 53899	Urinary	08%	83%	09%
54000 - 55980	Male Genital	10%	80%	10%
56300 - 56399	Laparoscopy/Hysteroscopy	09%	81%	10%
56405 - 58999	Female Genital	12%	74%	14%
59000 - 59899	Maternity	17%	60%	23%
60000 - 60605	Endocrine	09%	82%	09%
60650 - 60699	Endocrine	09%	84%	07%
61000 - 64999	Nervous System	11%	76%	13%
65091 - 68899	Eye/Occular	10%	70%	20%
69000 - 69979	Auditory	07%	79%	14%

Anesthesia [Refer to WAC 388-531-0300]

General Anesthesia

- MAA requires providers to use anesthesia CPT codes 00100-01999 to bill for anesthesia services paid with base and time units. Providers **must not use** the surgical procedure code with an anesthesia modifier to bill for the anesthesia procedure.

- MAA reimburses for CPT code 01922 for noninvasive imaging or radiation therapy when:

  - ✓ The client is 17 years of age or younger; or
  - ✓ There are client-specific reasons why the procedure cannot be performed without anesthesia services. Documentation must be kept in the client's medical record.

- MAA reimburses providers for covered anesthesia services performed by one of the following:

  - ✓ Anesthesiologist;
  - ✓ Certified registered nurse anesthetist (CRNA); or
  - ✓ Other providers who have a contract with MAA to provide anesthesia services.

- For each client, the anesthesia provider must:

  - ✓ Perform a pre-anesthetic examination and evaluation;
  - ✓ Prescribe the anesthesia plan;
  - ✓ Personally participate in the most demanding aspects of the anesthesia plan, including, induction and emergence;
  - ✓ Ensure that any procedures in the anesthesia plan that he or she does not perform are done by a qualified individual as defined in program operating instructions;
  - ✓ Monitor the course of anesthesia administration at frequent intervals;
  - ✓ Remain physically present and available for immediate diagnosis and treatment of emergencies; and
  - ✓ Provide indicated post-anesthesia care.

- In addition, the anesthesia provider may direct no more than four anesthesia services concurrently. The anesthesia provider may not perform any other services while directing these services, other than attending to medical emergencies and other limited services as allowed by Medicare policy.

- The anesthesia provider must document in the client's medical record that the medical direction requirements were met. Providers do not need to submit documentation with each claim to substantiate these requirements.

- Anesthesia time begins when the anesthesia provider starts to physically prepare the client for the induction of anesthesia in the operating room area or its equivalent. When there is a break in continuous anesthesia care, blocks of time may be summed as long as there is continuous monitoring of the client within the blocks of time. Examples of this include, but are not limited to: time a client spends in an anesthesia induction room or under the care of an operating room nurse during a surgical procedure. Anesthesia time ends when the anesthesia provider or surgeon is no longer in constant attendance (i.e. when the client can be safely placed under postoperative supervision).

- Do not bill CPT codes 01953 or 01996 with an anesthesia modifier or with the time in the "units" field. MAA has assigned flat fees for these codes.

- MAA allows the following two anesthesia codes published in the American Society of Anesthesiology (ASA) Relative Value Guide (RVG):

ASA Code	Description
02100	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider)
02101	Anesthesia for diagnostic or therapeutic nerve blocks and injections-patient in the prone position (when block or injection is performed by a different provider)

Use these ASA codes only when a provider, other than the one performing the block or the injection, administers anesthesia.

- MAA does not adopt any other ASA RVG codes that are not included in the CPT book. Bill all other anesthesia codes according to the descriptions published in the CPT book. When there are differences in code descriptions between the CPT book and the ASA RVG, MAA follows CPT code descriptions.

- MAA does not reimburse providers for anesthesia services when these services are billed using the CPT surgery, radiology, and/or medicine codes with anesthesia modifiers. **Continue to use the appropriate anesthesia modifier with anesthesia CPT and ASA codes.**

Exception: Anesthesia providers may bill CPT Pain Management/Other Services procedure codes that are not paid with base and time units. These services are reimbursed as a procedure using RBRVS methodology. Do not bill time in the unit field or use anesthesia modifiers.

- When billing anesthesia for surgical abortions (CPT code 01964), you must indicate in the *Comments* section of the claim form "voluntary or induced abortion."

- Do not bill CPT codes 00800-00882 or 00920-00952 for abortions, hysterectomies, or sterilization procedures. Use the appropriate CPT code.

- When multiple surgical procedures are performed during the same period of anesthesia, bill the surgical procedure with the greatest base value, along with the total time in whole minutes.

- When more than one anesthesia provider is present, MAA pays each provider 50% of the allowed amount. MAA limits reimbursement in this circumstance to 100% of the total allowed reimbursement for the service.

- Providers must report the number of actual anesthesia minutes (calculated to the next whole minute) in the appropriate field of the claim form. MAA calculates the base units.

Regional Anesthesia

- Bill MAA the appropriate procedure code (e.g. epidural CPT code 62319) with no time units and no anesthesia modifier. MAA determines payment by using the procedure's maximum allowable fee, not anesthesia base and time units.

- Local nerve block CPT code 64450 (other than digital and metacarpal) for subregional anatomic areas (such as the hand, wrist, ankle, foot and vagina) is included in the global surgical package and is not reimbursed separately.

Other

- Patient acuity does not affect payment levels. Qualifying circumstances (CPT codes 99100, 99116, 99135, and 99140) are considered bundled and are not paid separately.

- MAA follows Medicare's policy to not reimburse surgeons for anesthesia services. Claims for anesthesia services with modifier 47 will be denied. Under Medicare's payment policy, **separate reimbursement** for local, regional, or digital block or general anesthesia administered by the surgeon is not allowed. These services are considered included in the RBRVS payments for the procedure.

- When billing for anesthesia services using CPT **unlisted anesthesia code 01999**, **providers must attach documentation** (operative report) **to their claim** indicating what surgical procedure was performed that required the anesthesia in order to receive reimbursement. MAA will determine payment amount after review of the documentation.

Anesthesia for Maternity [Refer to WAC 388-531-0300(9)]

- MAA reimburses a maximum of 6 hours (360 minutes) of anesthesia for labor and delivery time (CPT codes 01960, 01961, 01967 and 01968) per delivery, including multiple births and/or cesarean section delivery.

- When billing more than one time-limited anesthesia code, the total time may not exceed 6 hours (360 minutes).

- Bill the applicable CPT anesthesia code with applicable modifier and time. To determine time for obstetric epidural anesthesia during normal labor and delivery and C-sections, time begins with insertion and ends with removal for a maximum of 6 hours per delivery.

- CPT codes 01968 and 01969 are anesthesia add-on codes to be used for cesarean delivery and cesarean hysterectomy following anesthesia given for a planned vaginal delivery. An additional base of 3 is allowed for 01968 and an additional base of 5 is allowed for 01969, in conjunction with the base of 6 for 01967. The time involved with each portion of the procedure should be reported with the appropriate CPT code. For example, if an epidural anesthetic is given to a client in labor for three hours while a vaginal delivery is still planned, the provider will report 01967 with a total time of 180 minutes. If the provider decides a cesarean section is then necessary, and the cesarean portion of the procedure takes an additional 30 minutes, the provider will report CPT code 01968 with a total time of 30 minutes on another line of the claim form. The provider will be reimbursed for a grand total of 9 base units and 210 minutes.

- The following obstetrical anesthesia codes are not subject to the 6-hour (360 minute) limitation: CPT codes 01962, 01963, 01964 and 01969.

- Anesthesia time for sterilization is added to the time for the delivery when the two procedures are performed during the same operative session. If the sterilization and delivery are performed during different operative sessions, the time is calculated separately.

Anesthesia Payment Calculation for Services Paid with Base and Time Units

- MAA's current anesthesia conversion factor is $20.24.

- Anesthesia time is paid using **one minute per unit**.

- Total anesthesia reimbursement is calculated by adding the base value for the anesthesia procedure with the actual time. Bill time in **total minutes** only, rounded to the next whole minute. Do not bill the procedure's base units.

The following table illustrates how to calculate the anesthesia payment:

Payment Calculation	
A.	Multiply base units by 15.
B.	Add total minutes to value from step A.
C.	Divide anesthesia conversion factor by 15, to obtain the rate per minute.
D.	Multiply total from Step B by the rate per minute in Step C.

Anesthesia conversion factor is based on 15-minute time units.

Anesthesia for Dental

General anesthesia is allowed when provided by an anesthesiology provider for dental admissions. Providers must use CPT anesthesia **code 00170** with the appropriate anesthesia modifier to bill for dental anesthesia.

☞ **Note:** Bill MAA directly for dental anesthesia for all clients, including those enrolled in an MAA managed care plan.

Pain Management Services

- Pain Management services and selected surgical services that are commonly performed by anesthesiologists and CRNAs are not paid with anesthesia base and time units. These services are paid using MAA's-assigned maximum allowable fee for the procedure code.
- Do not use anesthesia modifiers when billing for pain management and other services payable using MAA's-assigned maximum allowable fee. MAA denies claims for these services billed with an anesthesia modifier.
- Two postoperative procedures are allowed for pain management. Only one (1) unit may be billed per procedure. Do NOT bill time.

See next page for Pain Management Procedure Codes

Due to copyright restrictions, MAA publishes only official brief CPT descriptions
To view the full CPT description, please refer to your current CPT manual.

The listings shown below are not guaranteed to be all-inclusive, and are provided for convenience purposes only.

The codes listed in the following table with an asterisk (*) are limited to two (2) during the postoperative period while the client is admitted to the hospital. Do not bill modifier 59 with any of these procedure codes.

Procedure Code	Brief Description
11981*	Insert drug implant device
11982*	Remove drug implant device
11983*	Remove/insert drug implant
20526*	Ther injection, carpal tunnel
20550	Inject tendon/ligament/cyst
20551	Inject tendon origin/insert
20552	Inject trigger point, 1 or 2
20553	Inject trigger points, >3
20600	Drain/inject, joint/bursa
20605	Drain/inject, joint/bursa
20610	Drain/inject, joint/bursa
20612	Aspirate/inj ganglion cyst
27096	Inject sacroiliac joint
61790*	Treat trigeminal nerve
62264*	Epidural lysis on single day
62270	Spinal fluid tap, diagnostic
62272	Drain spinal fluid
62273*	Treat epidural spine lesion
62280*	Treat spinal cord lesion
62281*	Treat spinal cord lesion
62282*	Treat spinal canal lesion
62284	Injection for myelogram
62290	Inject for spine disk x-ray
62291	Inject for spine disk x-ray
62310*	Inject spine c/t
62311*	Inject spine l/s (cd)
62318*	Inject spine w/cath, c/t
62319*	Inject spine w/cath l/s (cd)
62350*	Implant spinal canal cath
62351*	Implant spinal canal cath
62355*	Remove spinal canal cath
62360*	Insert spine infusion device
62361*	Implant spine infusion pump

Procedure Code	Brief Description
62362*	Implant spine infusion pump
62365*	Remove spine infusion device
63650*	Implant neuroelectrodes
63655*	Implant neuroelectrodes
63660*	Revise/remove neuroelectrode
63685*	Implant neuroreceiver
63688*	Revise/remove neuroreceiver
64400*	Injection for nerve block
64402*	Injection for nerve block
64405*	Injection for nerve block
64408*	Injection for nerve block
64410*	Injection for nerve block
64412*	Injection for nerve block
64413*	Injection for nerve block
64415*	Injection for nerve block
64416*	Injection for nerve block
64417*	Injection for nerve block
64418*	Injection for nerve block
64420*	Injection for nerve block
64421*	Injection for nerve block
64425*	Injection for nerve block
64430*	Injection for nerve block
64435*	Injection for nerve block
64445*	Injection for nerve block
64446*	Injection for nerve block
64447*	Injection for nerve block
64448*	Injection for nerve block
64449*	Injection for nerve block
64450*	Injection for nerve block
64470*	Inj paravertebral c/t
64472*	Inj paravertebral c/t add-on

Procedure Code	Brief Description
64475*	Inj paravertebral l/s
64476*	Inj paravertebral l/s add-on
64479*	Inj foramen epidural add-on
64480*	Inj foramen epidural add-on
64483*	Inj foramen epidural l/s
64484*	Inj forament epidural add-on
64505*	Injection for nerve block
64508*	Injection for nerve block
64510*	Injection for nerve block
64517*	N block stellage ganglion
64520*	Injection for nerve block
64530*	Injection for nerve block
64550*	Apply neurostimulator
64553*	Implant neuroelectrodes
64555*	Implant neuroelectrodes
64560*	Implant neuroelectrodes
64561*	Implant neuroelectrodes
64565*	Implant neuroelectrodes
64573*	Implant neuroelectrodes
64575*	Implant neuroelectrodes
64577*	Implant neuroelectrodes
64580*	Implant neuroelectrodes
64581*	Implant neuroelectrodes
64585*	Revised/remove neuroelectrode
64590*	Implant neuroreceiver
64595*	Revise/remove neuroreceiver
64600*	Injection treatment of nerve
64605*	Injection treatment of nerve
64610*	Injection treatment of nerve
64612*	Destroy nerve, face muscle
64613*	Destroy nerve, spine muscle
64620*	Injection treatment of nerve
64622*	Destr paravertbrl nerve l/s
64626*	Destr paravertbrl nerve c/t
64627*	Destr paravertbrl nerve add-on
64630*	Injection treatment of nerve

Procedure Code	Brief Description
64640*	Injection treatment of nerve
64680*	Injection treatment of nerve
64681*	Injection treatment of nerve
64802*	Remove sympathetic nerves
64804*	Remove sympathetic nerves
64809*	Remove sympathetic nerves
64818*	Remove sympathetic nerves

Other Services

Procedure Code	Brief Description
36400	Drawing blood
36420	Establish access to vein
36425	Establish access to vein
36555	Insert non-tunnel cv cath
36566	Insert tunneled cv cath
36568	Insert tunneled cv cath
36580	Replace tunneled cv cath
36584	Replace tunneled cv cath
36589	Removal tunneled cv cath
36600	Withdrawal of arterial blood
36620	Insertion catheter, artery
36625	Insertion catheter, artery
36660	Insertion catheter, artery
62263	Lysis epidural adhesions
62287	Percutaneous diskectomy
63600	Remove spinal cord lesion
75998	Fluoroscope examination
76000	Fluoroscope examination
76003	Needle localization by x-ray
76005	Fluoroguide for spine inject
76496	Fluoroscopic procedure
93503	Insert/place heart catheter
95970	Analyze neurostim, no prog
95990	Spin/brain pump refil & main

These codes are paid as a procedure using MAA's maximum allowable fee, not with base units and time.

Major Trauma Services

Payment enhancements apply to nongovernmental Trauma Services. Physicians and clinical providers on the Trauma teams of governmental hospitals receive enhancements on a per patient basis. See page F.35 for a list of the Designated Trauma Services. Page F.36 lists the Department of Health's (DOH) categories of Physician and Clinical Providers for the Trauma Response Teams.

Payment Limitations for Major Trauma

To receive enhanced payment, DOH must identify the facility as a Designated Trauma Services. The facility's staff must maintain a quality improvement program and submit trauma registry data as prescribed by DOH. Verification of trauma service designation and patients' Injury Severity Score (ISS) is done by DOH.

Enhanced payments are limited to services provided by a member of a Designated Trauma Services Trauma Response Team for MAA clients who require major trauma services. Enhanced payments are limited to services performed in the hospital.

These enhancements are for fee-for-service MAA clients only.

Additional funds are available for treatment related to major trauma at Designated Trauma Services; however, **modifier ST must be entered on the claim form to receive the enhanced payment**.

☞ **Note:** The current Injury Severity Score (ISS) is 13 or greater for adults, and 9 or greater for pediatric clients (through 14 years of age only) and for transferred patients. Enhanced payment is available if the client meets these criteria.

Non-Designated Centers and Providers

Physicians and clinical providers not identified by DOH as Designated Trauma Services are reimbursed using MAA's maximum allowable fee schedule. A non-designated clinic that becomes designated during the course of the year must notify MAA at the address below of the change of status.

Medical Assistance Administration
Provider Enrollment Unit
PO Box 45562
Olympia, WA 98504-5562
(866) 545-0544

Billing

Professional providers must bill MAA for qualified trauma services by **adding modifier ST to the appropriate procedure code.** If it is necessary to bill using **two or more modifiers**, **add modifier 99** to the detail line along with all other applicable modifiers, including ST. **Modifier 99 must be listed in the FIRST position in the modifier field.** Billing all modifiers with modifier 99 ensures appropriate payment. Claims billed inappropriately must be rebilled on MAA's blue Adjustment Request Form (DSHS 525-109).

For Additional Information

For information on **trauma service designation, trauma registry, and/or injury severity scores (ISS)**, contact:

Chris Williams
Department of Health
Office of Emergency Medical & Trauma Prevention
(360) 705-6735 or 1-800-725-1834.

For information on **reimbursement**, contact:

John Hanson, Hospital Rates Unit Manager
Medical Assistance Administration
Hospital/Managed Care Rates Section
(360) 725-1834

For information on a specific **Medicaid trauma claim**, contact:

MAA's Provider Relations Unit
1-800-562-6188

DESIGNATED TRAUMA SERVICES

Nongovernmental Facilities:

Auburn Regional (Auburn)
Cascade Medical (Leavenworth)
Central Washington (Wenatchee)
Darrington (Darrington)
Deaconess (Spokane)
Deer Park (Deer Park)
Emanual (Portland)
Good Samaritan (Puyallup)
Grays Harbor Community (Aberdeen)
Gritman Memorial (Moscow, Idaho)
Harrison Memorial (Bremerton)
Highline Community (Burien)
Holy Family (Spokane)
Inter-Island (Friday Harbor)
Kadlec (Richland)
Mary Bridge's (Tacoma)
Mt. Carmel (Colville)
Northwest (Seattle)
Our Lady of Lourdes (Pasco)
Overlake (Bellevue)
Providence (Centralia)
Providence (Everett - Colby)
Providence (Toppenish)
Sacred Heart (Spokane)
St. Francis (Federal Way)
St. Johns (Longivew)
St. Joseph (Bellingham)
St. Joseph (Chewelah)
St. Joseph (Lewiston)
St. Mary Med. Ctr. (Walla Walla)
St. Peter's (Olympia)
Southwest Wash. (Vancouver)
Sunnyside Community (Sunnyside)
Tri-State Memorial (Clarkston)
Valley (Spokane)
Walla Walla General (Walla Walla)
Yakima Valley/Prov Yak Med (Yakima)

Governmental Facilities and their Trauma Service Level:

Level 1:
Harborview (Seattle)
Oregon Health Sciences (Portland)
* Designated by Oregon only

Level 2:
None

Level 3:
Island (Anacortes)
Kennewick General (Kennewick)
Skagit Valley (Mt. Vernon)
Valley Med. Ctr. (Renton)
Whidbey General (Coupeville)

Level 4:
Cascade Valley (Arlington)
Evergreen Hospital (Kirkland)
Forks Community (Forks)
Jefferson General (Pt. Townsend)
Kittitas Valley (Cle Elum)
Klickitat Valley (Goldendale
Lake Chelan Community (Chelan)
Lewis Co. Hosp. Dist. #1 (Morton)
Lincoln (Davenport)
Mason General (Shelton)
Mid Valley (Omak)
Newport Comm. Hospital (Newport)
North Valley (Tonasket)
Ocean Beach (Ilwaco)
Okanogan-Douglas (Brewster)
Olympic Mem. Hospital (Pt. Angeles)
Othello Community (Othello)
Prosser Memorial (Prosser)
Pullman Memorial (Pullman)
Samaritan (Moses Lake)
Skyline (White Salmon)
Stevens Memorial (Edmonds)
Valley General (Monroe)
Willapa Harbor Hosp. (South Bend)

Level 5:
Columbia Basin (Ephrata)
Coulee Community (Grand Coulee)
Dayton General (Dayton)
East Adams Rural (Ritzville)
Ferry Co. Memorial (Republic)
Garfield County (Pomeroy)
Kittitas Hosp. Dist. #2 (Cle Elum)
Mark Reed (McCleary)
Odessa Memorial (Odessa)
Quincy Valley (Quincy)Whitman County (Colfax)

PHYSICIAN/CLINICAL PROVIDER LIST

Advanced Registered Nurse Practitioner
Anesthesiologist
Certified Registered Nurse Anesthetist
Cardiologist
Critical Care Physician
Emergency Physician
Family/General Practice Physician with
Trauma Training
Gastroenterologist
General Surgeon
Gynecologist
Hand Surgeon
Hematologist
Infectious Disease Specialist
Internal Medicine
Nephrologist
Neurologist
Neurosurgeon
Obstetrician
Ophthalmologist
Oral/Maxillofacial Surgeon
Orthopedic Surgeon
Pathologist
Pediatric Surgeon
Pediatrician
Physiatrist
Physician Assistant
Plastic Surgeon
Pulmonologist
Radiologist
Thoracic Surgeon
Urologist
Vascular Surgeon

Note: Many procedures are not included in major trauma services enhanced payment.

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